COMMONWEALTH OF VIRGINIA

Department of Rehabilitative Services

PERSONAL ASSISTANT'S
CHANGE OF NAME/ADDRESS/TELEPHONE

_____

_____

E-mail Address: _____

Cell Phone #: _____

MAILING ADDRESS:

Department of Rehabilitative Services
PAS Program
Post Office Box 71958
Richmond, VA 23255

This is to certify that _____ has been employed as a Personal Assistant to _____ for a total of _____ hours shown below at **$8.86** per hour. The Assistant has earned _____ less cost share of _____ to be deducted biweekly and is due a total of _____

Timesheets cover 14 calendar days, not working days. Timesheets should be sent to DRS every other Wednesday. Please note number of hours worked by each date, using a separate timesheet for each pay period.

My signature on this form certifies that, to the best of my knowledge, all information is accurate, true and complete. I agree to give proof of this information if requested. I understand that giving inaccurate or misleading information, including false statements or forgery, may result in the suspension or loss of my services and may result in civil or criminal proceedings.

Approved by Assistant: _____

Date: _____

Authorized by Employer: _____

Date: _____

	DATE	HOURS		DATE	HOURS
Thursday			**Thursday**		
Friday			**Friday**		
Saturday			**Saturday**		
Sunday			**Sunday**		
Monday			**Monday**		
Tuesday			**Tuesday**		
Wednesday			**Wednesday**		
	TOTAL			**TOTAL**	

TOTAL HOURS _____

Revised 7/2009 – This form is on the DRS website: http://www.vadrs.org/formscabinet